FORM 140

The Commonwealth of Massachusetts
Department of Industrial Accidents
600 Washington Street – 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

TEMPORARY CONFERENCE MEMORANDUM COVER FORM

DIA Board # (If Known):

Please Print or Type

THIS CONFERENCE MEMORANDUM COVER SHEET , SIGNED BY COUNSEL SHALL BE FILED WITH THE ADMINISTRATIVE JUDGE AT THE START OF THE CONFERENCE.

CASE INFORMATION

1. Date (mm/dd/yyyy):	2. Conference Location:	3. DIA Board Number:
4. Claimant's Name & Address (No., Street, City, State & Zip Code):		5. Claimant's Tel. Number:
6. Name and Address of Claimant's Attorney:		7. Claimant's Attorney's Tel. Number:
8. Insurance Carrier's Name & Address:	9. Name & Address of Insurer's Attorney: Tel. Number:	
10. Employer's Name & Address:	11. Name & Address of Employer's Attorney: Tel. Number:	

EMPLOYEE & INJURY

12. Date of Injury (mm/dd/yyyy):	**13. Nature & Cause of Injury:**	14. Average Weekly Wage:	15. No. of Dependents:

16. Has Any Compensation Been Paid:
Yes ☐ No ☐
Accepted Liability ☐ Pay Without Prejudice ☐

17. If Yes for #16 Please State Period and Type:
From _____ To _____ and From _____ to _____
At a Rate of $_____ per Week Under §34
At a Rate of $_____ per Week Under §35 - Plus Dependency at $_____ /week

18. Claims for Compensation:

Temporary Total Incapacity - From _____ To _____ at $ _____ per week
OR
Partial Compensation - From _____ To _____ at $ _____ per week

Section 36 Benefits _____ OTHER (specify) _____

ISSUES IN DISPUTE

19. Issues in Dispute (Check all that apply):

Liability ☐ - Average Weekly Wage ☐ - Disability ☐ - Extent ☐ - Causal Relationship to Work ☐

Fraud ☐ (explain) _____ §14 (1) ☐ §14 (2) ☐

OTHER ☐ (specify)_____

_____

Dispute of Entitlement Due to Insufficient Documentation Filed ☐

Other Attorney Fee Issues _____

20. Is Impartial Medical Examination Required?:
Yes, Impartial Exam Will be needed ☐ - No Impartial Exam is needed ☐

(OVER)

PURSUANT TO 452 C.M.R. 1.10 (2), AS AMENDED, CHECK OFF THE DOCUMENTATION INCLUDED IN ATTACHED CONFERENCE MEMORANDUM:

DOCUMENTS TO BE SENT TO IMPARTIAL PHYSICIAN MUST BE SUBMITTED IN DUPLICATE AND ARRANGED IN CHRONOLOGICAL ORDER

EMPLOYEE	INSURER	ATTACHMENTS:
_____	_____	Stipulations of Fact.
_____	_____	Exhibits to be marked for identification at hearing.
_____	_____	Names of witnesses with summary of anticipated testimony.
_____	_____	Medical records to be sent to impartial examiner, accompanied by an itemized list of those records.
_____	_____	Hypotheticals to be sent to impartial.
_____	_____	Disclosure questions for impartial physician (not to exceed 3 in number).
_____	_____	Written objections to medical records submitted, starting with the reasons therefore.
_____	_____	Name(s) of additional physician(s) for who(m), at the time of hearing, it is anticipated either party will request a deposition.

PURSUANT TO 452 C.M.R. 1.10 (2), COMPLETE THE FOLLOWING:

MEDICAL ISSUE(S) IN DISPUTE: _____

_____

MEDICAL SPECIALTY OF IMPARTIAL PHYSICIAN _____

NAMES OF THREE IMPARTIAL PHYSICIANS THE PARTIES HAVE AGREED UPON IN ORDER OF PREFERENCE

1. _____

2. _____

3. _____

CHECK THIS BOX IF NO AGREEMENT CAN BE REACHED - ☐

ESTIMATED LENGTH OF HEARING _____

SIGNATURES:

EMPLOYEE'S COUNSEL _____ **INSURER'S COUNSEL** _____

EMPLOYER'S COUNSEL (if applicable) _____

FOR DEPARTMENT USE ONLY

DISPOSITION: ORD _____ **FROM** _____ **TO** _____

ATTORNEY FEE: $_____ **ADDITIONAL TIME ALLOWED TO FILE DOCUMENTS:** _____ **DAYS**

_____

_____